Gosport, Mass Killing, and the Culture of Death in the New World Order

by Jeremy James

The Word of God tells us that **"The heart is deceitful above all thing, and desperately wicked: who can know it?" (Jeremiah 17:9)**.

The influence of the ultra-rich Elite in human affairs would be far easier to understand if we studied their conduct in light of this remarkable statement. When compared to the total population of the world, their numbers are relatively small. But great wealth can buy incredible influence in human affairs. It can harness the cunning and intelligence of the most ingenious minds and use it to fashion and implement an invisible network of interlinked programs to take complete control of all national governments and forge a New World Order.

The Bible reveals the plan behind the New World Order

The Bible speaks of this conspiracy and the mentality behind it, which can be traced all the way back to the Garden of Eden. In particular it tells us that it will eventually culminate in the sequence of cataclysmic events that we know as The Great Tribulation.

Jesus warned us that Satan is both a murderer and a liar, qualities that have characterized his modus operandi throughout the ages. In previous papers we have looked mainly at his incredible use of lies and deception to get his own way and mould humanity in accordance with his End Time plan. We will now examine his use of murder and systematic killing to advance his cause.

The aspect of his murderous mentality that we propose to discuss is euthanasia, the killing of people on medical grounds. The target group usually comprises the elderly and infirm, but younger groups, such as persons with a physical or mental disability, are often included. The reasons generally given for this form of killing are: To allay unnecessary suffering; to relieve the patient of the need to commit suicide; to allow the patient to die at a time of his or her own choosing; to allow the patient to die with dignity; and to allow the medical resources and public funds consumed by the patient to be used for other purposes. The last is usually predicated on the argument that the patient has no further economic utility and has already consumed more than his 'fair share' of available resources. We won't try to refute these strange and disturbing arguments, but will concentrate mainly on the act itself and how it fits into the plan for a New World Order.

Gosport War Memorial Hospital

We have already shown in previous papers how the Elite want to greatly reduce the world's population. They view mankind as a herd that needs to be culled from time to time. However, the methods employed to date – war, abortion, untreated disease, and famine – have had only limited success. They now want to add mass sterilization and systematic euthanasia to their list.

Involuntary Euthanasia

The problem with euthanasia as a culling method is that it works best when it is implemented on an involuntary basis. Given a choice most elderly people would choose to stay alive! The Elite are trying to get around this by various sophistical arguments in the media and elsewhere, most of which rely on guilt. Seemingly we have a 'carbon footprint' and our very existence is a threat to the well-being of the 'planet'. If we had a truly altruistic attitude, we would gladly leave this earth as soon as our productive years had come to a natural end. Only a selfish person would want to prolong his life beyond the point where he had no economic value whatever and was a continuing drain on the community, the nation, and the 'planet'. These destructive attitudes are being programmed into our children through television and other means. The 'Green' philosophy portrays man as just another species of animal, with no more right to life than, say, a gorilla or an orangutan.

This cheapening of human life is greatly reinforced by the endless movies, television series, and computer games which treat the moment of death as merely a terminal episode in a series of otherwise mundane events. The horror and finality of death is either ignored or, worse still, transmuted into entertainment.

The Elite want to convince the public that the value of human life is quantifiable and that every human must justify his or her existence. They have already tricked most countries into introducing laws to facilitate abortion on demand. In effect, they have got the public to believe that an unborn child has value only if his mother decides that he has. The same kind of perverted logic is being used to undermine the 'value' of an elderly person's life. This 'value' is dependent upon, and directly proportional to, the importance that other family members attach to that person. Euthanasia, especially the kind the Elite prefer – involuntary euthanasia – would be easier to implement if they could weaken the attachment and sense of responsibility that the younger generation feel for near relatives of advanced age. How far would they go to protect them? The case we are about to consider, which involved mass murder on a horrifying scale, may have been designed by the Elite to answer this question.

The Minister for Health and Social Care apologizes in Parliament for the huge unexplained death toll at Gosport Hospital, 20 June 2018

Report of the Gosport Independent Panel

The Report of the Gosport Independent Panel, which was published in June of this year, should have attracted headlines across the world. It contained startling revelations about atrocities not normally seen in peacetime, carried out by an institution dedicated to protecting and preserving life. However, it received so little coverage in the media, even in the UK where these events occurred, that few people have heard of it or understand its sinister implications for democracy.

> **"Where do we even begin? How do mere words encapsulate the full horror of the Gosport War Memorial Hospital (GWMH) report… and its profound implications for nursing? …The substance of this report into the killing fields of GWMH is as chilling as it is damning."**
>
> **– Professor Philip Darbyshire**

We will give extensive extracts from the Report since it provides verifiable evidence, backed up by extensive documentation, that a crime of monumental proportions was systematically covered up by the British Establishment for nearly 20 years. Just as importantly, it shows that the crime itself could only have been carried out with the complicity and knowledge of many highly placed professionals within the British medical establishment, law enforcement, and certain other public bodies. Along the way, it reveals extraordinary arrogance at the highest levels and a contempt for justice and democracy which the average person would simply not believe were it not so carefully and extensively documented in the Report.

Background to the Report

The Report addresses the circumstances surrounding the exceptionally high number of deaths at Gosport War Memorial Hospital in Gosport, England, between 1989 and 2000. Most of the patients who died had only been recently admitted, had no life-threatening illness, and were expected in due course to make a full recovery. Even though many were elderly and fragile, they were not admitted for palliative care. [Palliative care is the term normally used to denote the medical treatment of patients who are terminally ill, where the main focus is on the alleviation of pain and discomfort during their final phase of life.] Following a steady stream of complaints and disturbing reports from bereaved relatives over a period of 15 years or more, the Government finally granted an independent enquiry. The Parliamentary Under-Secretary of State at the Department of Health, Norman Lamb MP, announced the Panel's Terms of Reference in a Written Parliamentary Statement on 9 December 2014. The Panel met for the first time on 13 January 2015 and on a monthly basis thereafter. Its Report, which runs to more than 380 pages, was published in June 2018. It concluded that, over a period of 10 years or so, the staff at Gosport War Memorial Hospital were guilty of the unlawful killing of over 650 patients. The circumstances of these killings, the steps taken to conceal what was happening, and the complicity of dozens of trusted persons in positions of authority are chilling in the extreme.

Relatives of the patients killed at Gosport War Memorial Hospital.

Matters covered by the Report

The general tenor of what was happening at the hospital is well exemplified by the following three extracts from the Report. [The term 'syringe driver' refers to a device which automatically delivers a specified dose of a medication by syringe over a set period of time. It does so by 'driving' or pressing the syringe pump in accordance with the rate set by the medical staff.]

> "This same theme emerges time and time again from the families' experience. For example, the daughter of one patient discovered that a syringe driver had been inserted. She queried this because she knew her father wasn't in pain and didn't need it, but ward staff were dismissive, telling her she was not a nurse and that they were the professionals. She was furious and called her father's GP, who arranged for the syringe to be taken out and for her father to come home." [2.7]
>
> "Another patient was admitted for respite care but deteriorated and became confused during his stay. Staff asked permission to give him diamorphine but his daughter refused, as he was not in pain. However, her mother later agreed and he was started on diamorphine by syringe driver. He died the same day." [2.8]
>
> "A man admitted for dementia was started on a diamorphine syringe driver. Staff asked his son for permission and he gave it but felt there was no explanation of what it meant to be given diamorphine. The dose was doubled and his father died five days later. He son felt the diamorphine effectively killed him." [2.9]

Seemingly all of the fatalities considered in the Report were caused by an overdose of opioids administered by a syringe driver. Opioids (or opioid analgesics) are a group of drugs used to treat moderate to severe pain, most commonly in trauma or heart attack, and in the palliative care of people with terminal cancer or other end-of-life condition. They comprise a wider group of drugs than those which occur naturally in opium. These synthetic or semi-synthetic variants include diamorphine, pethidine, fentanyl and tramadol. [2.12-13]

Graseby syringe driver, similar to the ones used at Gosport.

Diamorphine

Diamorphine was first derived from morphine in 1874 and marketed over-the-counter under the trade name 'heroin'. Pethedine, a totally synthetic opioid, was introduced in 1939 and widely used in obstetrics for many years. Fentanyl, another highly potent synthetic opioid, was discovered in 1960. Since it can be absorbed through the skin it has been widely used in dermal patches.

Opioids have an extremely narrow margin of safety. The ratio between a therapeutic dose and a harmful dose is very small. A dose of just 30mg could be fatal for a person with no previous exposure to diamorphine, while a single dose of 5-10mg would provide profound pain relief. The notorious serial killer, Dr Harold Shipman, murdered many of his victims with just a single 30mg dose of diamorphine, which normally caused death by respiratory arrest. [2.20-21]

The UK is unique in that diamorphine is widely used in healthcare. In most other countries its use is either discouraged or unlawful, largely because it is identical to the street drug, heroin.

The principles for the safe and effective use of opioids in both palliative and non-palliative care, either alone or in combination with powerful tranquilizers, were already well established before the unlawful killings at Gosport had commenced. Authoritative national and international recommendations pertaining to their use were incorporated into the guidelines issued to National Health Service (NHS) staff.

The UK healthcare guidelines emphasize that it is essential to use the analgesic which is appropriate to the severity of the pain. It advocates the WHO 'analgesic ladder' which employs a 3-step approach: (1) use non-opioids first, e.g. ibuprofen; (2) use weak opioids (such as codeine) if step 1 is not working; (3) introduce strong opioids next, but do so slowly, monitoring their effect. A syringe driver should be used only where the patient has difficulty swallowing oral medication.

In its analysis of the medical records, the Panel found an alarming number of instances of "Opioid use without appropriate clinical indication." These were administered continuously via syringe driver and "started at inappropriately high doses." In addition they were frequently combined "with other drugs in high doses." The Report notes that "Few patients survived long after starting continuous opioids" [2.96]. In these eight anodyne words the Report sums up a killing spree that ran for a decade. On average the persons responsible murdered a patient every 5 days for about ten years.

The Killing Fields: The number of patients who were murdered

A total of 2,024 patients were known to have died in the hospital between 1987 and 2001. The hospital records of 1,564 of these patients were located by the Panel. Out of these 1,043 contained sufficient information to enable the Panel to decide whether there was evidence of opioid usage without appropriate clinical indication. In all, the Panel identified 456 such cases ("This may only have been the tip of a more lethal iceberg however." – Darbyshire). They then added a further 200 "at least" to account for estimated deaths "without appropriate clinical indication" among the 981 patients whose records were either not found or had insufficient information.

In our opinion, this figure (200+) seems far too low. If, among those patients whose records were sufficiently complete to allow a view to be formed, the proportion of affected cases was 44% (456 out of 1,043), then it is reasonable to assume that the proportion of similar cases among the remaining 981 – whose records may have been insufficiently detailed or even deliberately suppressed in order to hide irregularities – was also of the order of 44%, if not higher. If so then an additional 431 cases (and not 200+) should be added to the 456 cases positively identified. This would raise the total number of unlawful deaths at Gosport over this period to 880 or more.

Age and physical condition of the patients

None of the patients admitted to Gosport were in the category that would normally require "palliative care." Gosport itself was a general hospital, offering the standard range of therapeutic services for people in the surrounding community. Many of the elderly people who died under suspicious circumstances at the hospital had been admitted for rehabilitation or respite care. Their ailments, which were not life-threatening, included bone fractures, arthritis, dementia, hip replacements, impaired mobility, sacral sores, or the after-effects of a stroke.

The one factor that all victims had in common was that they were nearly all aged over 60. In one cohort of 134, 10% were in their 60s, 30% in their 70s, 44% in their 80s, and 16% in their 90s.

How the killings were carried out

In the great majority of patients, the opioid used was diamorphine administered via a syringe driver, often in conjunction with other drugs, particularly *midazolam* [a sedative] and *hyoscine* [a sedative], over the last days of life. This pattern was confirmed by the victims' families.

In her whistleblower statement to the police in April, 2001, nurse Pauline Spilka said, "The needle [of the syringe driver] would be inserted into the patient's back so as to make it impossible for it to be removed."

The treatment would appear in almost all cases to have involved 'anticipatory prescribing' – prescribing a drug in advance to meet a possible future clinical need. If used in accordance with strict standards this is regarded as a safe and effective practice in palliative care medicine. However, as the Report states, "its use was not well established in the 1990s." Furthermore, the hospital was not providing palliative care. "The Panel therefore found it particularly surprising to see this practice extended to [patients] …whose stay at the hospital was elective, that is to say planned and predominantly for a short period, and to patients admitted for rehabilitation." [p.38]

The victim's families expressed great concern over the scale and extent of this practice at Gosport; the dose ranges prescribed; the degree of delegation to nurses to start treatment and increase doses; and the dangers inherent in this practice.

Regarding the dosage levels being prescribed (or pre-prescribed) the Report states:

> "The records show that practice at the hospital included anticipatory prescribing of diamorphine [heroin] by syringe driver in a very wide dose range of either 20-100 mg per 24 hours or, more commonly, 20-200 mg per 24 hours, with no specified trigger for the start or escalation of dosage." [2.108]
>
> "...the range prescribed often went as high as 100 mg per 24 hours or even 200 mg per 24 hours...it is remarkable that so many patients were judged to require such a high initial dose. This is even more striking for those patients in whom there was no appropriate clinical indication for the diamorphine usage, with 57% receiving an initial dose of 40 mg per 24 hours or higher." [2.117]

The term "no appropriate clinical indication," which appears throughout the Report, is extremely important. The Panel is saying that a powerful opioid was administered for no clinical purpose ("We are not making this up or exaggerating here." – Darbyshire). In short, the patient did not need it and there were no observable signs that he or she could possibly need it. What is more, according to these extracts, the dose given could be set at whatever level the nurse decided – again without any clinical indication. In practice the doses selected were invariably far higher than one would expect, *even if* a strong opioid was clinically indicated.

These assertions by the Panel are damning in the extreme. The Report also states:

> "Given the high doses of diamorphine prescribed, often without appropriate clinical indication, the addition of further drugs with few references to any clinical requirement for them is remarkable...It is equally surprising that, considering the amount of opioids being used, there is not a single example in any of the records we have seen where the antidote to opioids, namely *naloxone*, was considered." [2.122]

In what is probably the most startling statement in the Report, the Panel noted:

> "The survival of patients who were started on continuous diamorphine via syringe driver was inevitably measured in days, usually very few." [2.123]

Of those who were administered continuous diamorphine alone, without appropriate clinical indication, 59% were dead within two days. When diamorphine was combined with *midazolam* and *hyoscine*, 71% were dead within two days. In fact, half died on the same day or the following day.

Official cause of death

Before we discuss the official cause of death recorded in the respective death certificates, it may help at this point to mention the case of a man who survived the regime at Gosport:

> "One of the letters was from Paule Ripley, who explained that, although her husband James Ripley, had survived his stay at the hospital in April 2000, she wished for the circumstances surrounding his care to be investigated. The nature of her concern was that, having been admitted to the hospital for rest and care to treat a serious flare-up of arthritis, her husband became unconscious on 9 May 2000. He was said to have suffered a stroke and was transferred to Haslar Hospital where, in fact it was discovered that he had not suffered a stroke. Rather, he had suffered an analgesic overdose and was so severely dehydrated that he had been hallucinating…Mrs Ripley stated that she was aware of other cases that were similar to her husband's." [5.182] (emphasis added)

The medical staff at Haslar Hospital had correctly diagnosed what had happened to Mr Ripley (believe it or not). He had 'suffered' an analgesic overdose and would surely have died had he not been removed from Gosport.

Gillian Mackenzie holding a photo of her mother Gladys Richards.
Mrs Mackenzie has fought her mother's case for nearly 20 years.

However, 'analgesic overdose' was never given as the cause of death on any of the death certificates pertaining to the 800 or more victims at Gosport.

As the Report states:

> "The recorded causes of death for those who died in the hospital are also instructive. The most notable feature immediately apparent on examining the death certificates was the frequent occurrence of bronchopneumonia as a cause of death: bronchopneumonia was cited as the immediate cause of death in 796 patients (39%)." [2.133]

Bronchopneumonia is broadly defined as an infection of the lungs and small airways that may occur as a terminal event in patients who have suffered acute illness over a period from some other cause. While it can be recorded as the 'immediate' cause of death, it cannot be considered the primary cause. For example, a person who has been ill from cancer for some time may finally succumb to bronchopneumonia. Since the primary or underlying cause of death was cancer, this fact should be recorded on the death certificate.

The Panel believed it was "notable" that a quarter of all patients who died in the hospital over this period had no other certified cause leading to death than bronchopneumonia [2.134].

This is one of many understatements scattered here and there throughout the Report. The systematic failure to record the true cause of death in hundreds of cases is more than just "notable" – it is criminal.

The Panel members went to great lengths to avoid describing any aspect of this sordid business as criminal, seemingly because such judgments were outside their terms of reference. Nevertheless, there were numerous occasions when their description of events at Gosport – having regard to their cruelty, severity, and psychopathic character – was seriously inadequate. Matter-of-fact descriptions of horrific events only serve to sanitize and disguise the sheer evil in the hearts of those responsible.

Relatives protest outside the General Medical Council in London.

A presumption of death – '*Please make comfortable'*

The Report states that it was common practice at the hospital to anticipate the patient's death when prescribing opioids. This was evident from the clinical notes where the phrase, "*Please make comfortable*" or "*I am happy for nursing staff to confirm death*", was frequently used by the doctor in charge. This meant that she had delegated authority to the nurse on duty to officially confirm that the patient was dead. The deceased could then be removed from the ward without having to wait for a doctor to confirm death.

The Report touched on the truly sinister nature of what was happening when it stated:

> "There is a pattern across the cases reviewed by the Panel. On admission or close to admission, there is an assumption, not shared with the family, that the patient is close to death regardless of the purpose of their admission or the clinical management plan in place. So when the clinical staff said to families that they were making their loved ones "*comfortable*", that expression was a euphemism for embarking on a pattern of prescribing which would lead to death in almost every case." [3.77]

The relatives who left their loved ones in the care of the hospital staff did not realize that they were facing certain death, that a program of involuntary euthanasia was in operation and that, regardless of their underlying health condition – which was never indicative of a need for palliative care – the patient was terminated within two days.

The Report does not speculate on the criteria used by the nursing staff to select their victims. Perhaps they took into consideration the interest expressed by relatives in the quality of care that their loved one would receive, the tenor of the medical notes supplied by the GP, or some similar factor. Or, as one medical expert suggested, the deaths may have arisen only when certain staff were on duty.

The startling absence of patient medical records

As Professor Darbyshire noted in his examination of the Report, "nursing documentation was appallingly inadequate. There were often no nursing assessments or notes regarding pain, distress, medication changes, PRN medication commencement, reactions to medications given and much more."

There were no notes or records giving the reasons why the patient was started on a syringe driver loaded with diamorphine and other drugs; there were no notes or records outlining any discussions, conversations or planning between nurses, patients and family about end-of-life care; there were no notes or records describing how the patient was reacting or responding to major opiate mixtures; there were no notes or records that would indicate why a patient's diamorphine dose should be raised or even doubled by nursing staff to anywhere between the allowed "anticipatory prescribing" range of between 20-200mg; and ("with the notable exceptions of those who alerted management initially in 1991") there were no notes or records that would indicate that any nurse at any time had sought to challenge the treatment routinely given to patients.

Why did other medical staff remain silent?

The Report does not give sufficient attention to a question of burning concern – why didn't other medical staff notice what was happening or, if they suspected that something was amiss, why didn't they speak out?

The Panel states: "Even superficial monitoring of pharmacy data should have sounded alarm bells." [2.79] The façade was maintained by a very poor standard of record keeping, including poor recording of the clinical justification for the administration of opioids and powerful sedatives to newly arrived patients [p.76]

The nursing staff were authorized to act as they did by the medical professional in charge, Dr Jane Barton. However, Dr Barton's prescribing pattern was subject to scrutiny by two senior consultants, professionals with more than enough experience to detect serious violations of standard medical procedures. The Report states:

> "Although the consultants were not involved directly in treating patients on the wards, the medical records highlighted in this chapter show that they were aware of how drugs were prescribed and administered but did not intervene to stop the practice." [p.77]

The Panel also stated that there was "no evidence available to the Panel to suggest that either the pharmacists or Portsmouth HealthCare NHS Trust's Drugs and Therapeutic Committee challenged the practice of prescribing which should have been evident at the time." [p.77]

> "Nurses failed at almost every possible juncture to provide individualised care, to protect patients, to keep the most rudimentary of 'good records', to work as a trusted partner with families and relatives, to challenge or question clinical or pharmacological decisions based on sound clinical judgement, to escalate safety and care quality concerns to the point of action, to manage services with the patient as the priority and central focus and to think reflectively and critically about what was happening to their patients and at their hospital."
>
> – Professor Philip Darbyshire,
> *The Gosport War Memorial Hospital Panel Report and its implications for Nursing,*
> Journal of Advanced Nursing, 02 July 2018

In his analysis of events at Gosport, Professor Darbyshire drew attention to a pattern which was common to many similar instances of corporate medical misdemeanors:

1. Families and relatives who asked questions or raised concerns were marginalised, ridiculed, ignored, and demonised.

2. Nurses who raised red flags and tried to escalate concerns were branded as troublemakers. Their concerns were treated briefly as 'legitimate' but then interpreted instead as 'allegations' and 'disruptive criticism.'

3. Police inquiries and investigations were extremely badly handled.
4. Police inquiries and investigations were used as an excuse by other organizations with a responsibility in the matter (NHS, GMC, CPS, etc) to remain aloof from any involvement.
5. When they did become involved, the organizations concerned invariably acted to protect the medical professionals and hospital staff. The needs of patients and the concerns of relatives were of far less importance.
6. Vital notes, clinical records, minutes, and other documents mysteriously went missing.
7. "No opportunity to stonewall, delay, obfuscate, buck-pass and deny was missed by professionals, organisations and regulators alike."

These read like chapter summaries from the 'Cover-up Handbook.'

Attempts to establish the facts in one case

The relatives of Mrs Gladys Richards, who died under suspicious circumstances at Gosport hospital on 21 August 1998, brought their concerns to the Hampshire Constabulary. The latter decided to engage the services of Professor Brian Livesley, consultant physician at Chelsea and Westminster Hospital. Professor Livesley was provided with a detailed summary of Mrs Richards' case on 22 November 1999.

Professor Livesley submitted a draft report to the constabulary in May 2000. He was of the view that Mrs Richard's death was directly attributable to the administration of the large doses of drugs that she continuously received by syringe driver between 18 and 21 August 1998; that no event occurred to break the chain of causation; and that there was no evidence that her death caused by pneumonia. He also confirmed that he would support allegations of assault and "the unlawful killing of Mrs Richards by gross negligence" against the nursing staff and Dr Barton. In addition he suggested that the police undertake other enquiries to determine if other patients at the hospital had been similarly affected.

5.143 Professor Livesley's opinion, as reported by Mr Perry, was that:

> "Mrs Richards was unlawfully killed, by the continuous administration of drugs actively prescribed by Doctor Barton. He further concludes that Philip Beed, Margaret Couchman and Christine Joice knowingly and continuously administered diamorphine, haloperidal, midazolam and hyoscine to Mrs Richards when they should have recognized the fatal consequences of doing so."

One would think that this report, albeit in draft form, would have initiated a full scale enquiry into events at Gosport, both by the police and by the National Health Service (NHS). Incredibly that did not happen. Instead, as the Report notes, "Professor Livesley attended a conference on 19 June [2001 – NB!] with Mr Perry, Det Supt James and Mr Close, and subsequently described the two-hour meeting in the following terms: 'I was verbally abused, bullied, and attacked by Mr Perry so much so that I complained loudly that this was not professional.'" [5.129] Following another meeting with Professor Livesley, Mr Perry concluded that Professor Livesley's position was untenable and that he could not be relied upon as an expert witness in this case. [5.145]

Six investigations into police conduct

In all there were three police investigations, but they all went nowhere. The families of the victims were greatly disturbed by this and demanded further investigations – six in total – into what the police had done or failed to do. As the Report states: "During that period [1998-2007], six investigations into police conduct were carried out and six reports were produced on various aspects of the three investigations." [5.259]

Regarding one of the investigations, pertaining to events in 1991, the Report states: "The Panel has not seen any document to confirm on what basis the police determined that no offences had been committed in respect of the 1991 events. The Panel notes that the investigation into the 1991 events was incomplete in that the police had not sought to establish the specific details of the nurses' concerns, the chain of command on the wards and the hospital, and the persons responsible for implementing the use of syringe drivers and diamorphine…" [p.165]

All of this defies belief. Unfortunately the Report deals with this aspect of its enquiry in a very convoluted way. As a result its account of events between 2001, when the killings stopped, and 2009, when Dr Barton was finally brought before the Fitness to Practice Committee of the General Medical Council (GMC), is not entirely satisfactory.

The GMC might have acted sooner but, as the Report states, the constabulary wrote to the GMC asking that it defer its proposed fitness hearing on Dr Barton until it had completed its investigation: "By accepting the police's request, the GMC's investigation effectively stalled. As a result, the hearing which had been set for April 2003 did not take place until June 2009." [6.112]

Interim Orders Committee

On foot of the many complaints made to the General Medical Council about Dr Barton, commencing in 2000, the GMC referred her case to what was then known as the Interim Orders Committee (IOC). The IOC had the authority to suspend a doctor's registration, or to impose restrictive conditions on his/her registration, pending the outcome of a full hearing (which would take place before the Fitness to Practice Committee). In all Dr Barton appeared before the IOC on 5 separate occasions, seemingly in response to new evidence or cases not previously considered. The dates of the five separate IOC hearings were:

1. 21 June 2001
2. 21 March 2002
3. 19 September 2002
4. 7 October 2004
5. 11 July 2008

The IOC did not make an order on foot of any of the first 4 meetings, meaning that Dr Barton could continue to practice as before, without any formal restrictions. However, the IOC took account of her "voluntary" (unenforceable and unsupervised) agreement to not prescribe opiates or benzodiazepines. It was only at the fifth meeting that the IOC issued an order to formally withdraw her right to prescribe opiates or benzodiazepines. In short, it took 8 years before the GMC imposed this sensible and obvious restriction.

The Baker Report

A newly established body, the Commission for Health Improvement (CHI) got involved on foot of information it had received about practices at Gosport. The CHI began its investigation in September 2001 and published its report on 3 July 2002.

While it did not have the statutory authority to investigate the circumstances surrounding a particular death or the conduct of a particular staff member, it gave a sufficiently candid and detailed account of the situation at Gosport to alert the Chief Medical Officer (CMO) – the most senior medical advisor to the Government – to the possibility of serious malpractice at the hospital. He had also seen Professor Livesely's report in confidence which he said "makes worrying reading." The CMO immediately commissioned Professor Richard Baker to investigate the high death rate at Gosport. Professor Baker had previously carried out a similar audit in relation to deaths attributed to Dr Harold Shipman (the GP who murdered several hundred of his patients using diamorphine).

Professor Baker's investigation began on 13 September 2002. In the course of his work he came across a dossier of papers relating to attempts made in 1991 by some nurses at the hospital to challenge the treatment regime. This discovery appears to have caused some consternation at the Department of Health.

Professor Baker submitted his report to the CMO on 11 June 2003. It was based on a detailed analysis of the records of 81 suspicious deaths at Gosport. He concluded that there were serious irregularities at Gosport over a period of several years, leading to the unlawful killing of many patients. However, the government's legal adviser said that, since publication would prejudice any criminal trial against Dr Barton, it should not be published. As a result the contents of the report by Professor Baker did not become public until 2 August 2013!

Timeline of events between 1998 and 2009

It may help to reproduce here a timeline of the steps taken between 1998 and 2009 to establish what had transpired at Gosport War Memorial hospital. It was published by the *Independent on Sunday* on 15 March 2009, just a few days before the inquests approved by the Home Secretary were scheduled to begin:

> **1998:** Gillian Mackenzie reports her mother's death to Hampshire Constabulary which launches an investigation. No charges.
>
> **1999:** A second police investigation is launched after several families come forward with concerns. No charges.
>
> **July 2000:** The General Medical Council first becomes aware of concerns relating to Dr Jane Barton.
>
> **June 2002:** Mrs Mackenzie asks the GMC formally to investigate Dr Barton; she is informed there are no grounds for any action.
>
> **July 2002:** The Commission for Health Inspection finds systemic failings in the monitoring and prescribing of medication for elderly patients at Gosport. In November 2002, the NHS Trust which runs Gosport issues an action plan in response.
>
> **September 2002:** Chief Medical Officer orders an independent audit into the deaths. This report [the Baker Report] has never been made public. [*Note: It was eventually made public in 2013.*]

September 2002: Police begin a third investigation.

October 2007: CPS concludes there is insufficient evidence to prosecute any health professionals. Police reports are passed to the Portsmouth coroner, David Horsley, in early 2008.

May 2008: The Justice Minister, Jack Straw, announces an inquest into 10 of the deaths.

July 2008: GMC issues an interim order against Dr Barton which allows her to keep working with some restrictions.

18 March 2009: Inquests into 10 deaths begin.

Apart from the remarkable intransigence shown by the responsible authorities over a ten-year period, perhaps the most disturbing aspect of this timeline is the complete failure to hold anyone to account or any recognition that the pattern of unlawful killing might still be continuing.

The role of the Coroner

When, after a very considerable delay, the Department of Health finally gave approval for inquests to be held, the Coroner decided that only 10 cases would be examined (out of the 600 or more identified by the Panel in its Report). Given the issues at stake – not to mention the legal entitlement of the relatives to learn what happened to their loved ones – this was a startlingly small number. Even the police, in their third investigation, looked at 92 cases.

The Panel noted that "a Coroner is required to hold an inquest in cases where he/she has reasonable grounds to suspect that the deceased had died a violent or unnatural death or has died a sudden death of which the cause is known." (8.29) A case does not need to entail the possibility of criminal activity in order to fit this definition, so if the police saw fit to examine 92 cases, why did the Coroner confine his examination to just 10? The Report suggests that the Coroner was influenced in his decision by deficiencies in the information supplied to him by the police in 81 other cases. (8.38)

Department of Health and Social Care, Whitehall, London.

The inquest hearings, which commenced on 18 March 2009, considered 21 days of evidence. This was more than two years after the Coroner himself had formed the view that the inquests were necessary. What is more, as the Panel notes, nobody involved in the management of the hospital or any senior administrator gave evidence at the inquests! The Report also indicates that some expert witnesses were not allowed to testify, that some had been coached by the police, and that others had been denied access to all records relevant to the case they were commenting on. The Coroner also rejected submissions that contained evidence of unlawful killing which, in his opinion, did not meet the standard of proof required.

> "In resisting requests to widen the expert evidence...the Coroner appears from the records to have used reasons based on his own view as to why some reports were inadmissible and should not be relied upon. As a result of the approach taken, the records show that no independent expert evidence from a toxicologist or pharmacologist was sought, despite the central issue of the prescribing of diamorphine."
>
> **Gosport Hospital Report, 2018 [p.261]**

The verdicts were astonishing. The jury decided that in all ten cases the drugs had been given only for therapeutic purposes. It also decided that in 5 of the 10 cases the medication used to treat and relieve their symptoms did not contribute to their deaths.

Leslie Pittock, 83;
Elsie Lavender, 84;
Helena Service, 99;
Ruby Lake, 85;
Arthur Cunningham, 79;
Robert Wilson, 73;
Enid Spurgeon, 92;
Geoffrey Packman, 68;
Elsie Devine, 88;
Sheila Gregory, 91.

Cases examined at the formal inquest. The persons concerned all died while being treated on the Dryad and Daedalus wards between 1996 and 1999.

Fitness to Practice Hearing

In face of growing public awareness of events at Gosport, helped in no small measure by the *Independent on Sunday* and the angry response to the inquest verdicts, the General Medical Council (GMC) finally convened a fitness to practice hearing into Dr Barton. Even though the documents show that the General Medical Council had evidence against other doctors, it decided to confine its investigations to Dr Barton [p.216].

The hearing, which was held in London, began on 8 June 2009 and lasted a total of 37 days. Only 12 specimen cases were discussed during the 37 days.

At one stage during the proceedings the Chairman asked a doctor who had worked at Gosport: "Can you recall a single instance in your year on Dryad Ward where a patient was put on a mix of opiates or syringe driver who did not die?" He replied: "No, I cannot."

It also emerged during the hearings that there were NO facilities on the two wards in question – Daedalus and Dryad – for intravenous hydration, therefore patients who were unable to swallow – because they were heavily sedated – would not receive hydration, "which ultimately leads to death" [p.191] The Panel failed to comment further on this remarkable finding in its Report! Effective hydration is such a central feature of therapeutic care that its deliberate withdrawal in these cases was tantamount to unlawful killing.

The verdict said (in effect), *Don't do it again*

After a delay of several months, the panel concluded on 29 January 2010 that Dr Barton was guilty of multiple instances of serious professional misconduct. However, as hard as it is to believe, she was not struck off. The FtP panel said instead that it was "greatly impressed by the many compelling testimonials which detailed Dr Barton's safe practice over the past ten years" and believed it was in the public interest to preserve Dr Barton's services as a GP (general practitioner).

In approving this course of action, it attached a number of conditions to her continuance as a general practitioner. These included a requirement that she not prescribe or administer opiates by injection, that she not undertake palliative care, and that she serve in a group practice with at least three other GPs.

There was a general outcry from many members of the public when this verdict was read out.

The verdict was so preposterous that the Chief Executive of the GMC issued a press release which said:

> "We are surprised by the decision to apply conditions in this case. Our view was that the doctor's name should have been erased from the medical register following the Panel's finding of Serious Professional Misconduct. We will be carefully reviewing the decision before deciding what further action, if any, may be necessary."

The British Medical Association condemned the Chief Executive for taking this unprecedented step, stating that it was "tantamount to an interference in due process."

Neither the GMC nor the relatives could appeal the verdict to the High Court. This could only be done through the CHRE (Council for Healthcare Regulatory Excellence). Having examined the matter the CHRE concluded in March 2010 that, while it would have been appropriate to strike Dr Barton from the register, "the test had not been met to refer the case to the High Court for appeal."

Another police investigation

The intense controversy generated by the handling of the various enquiries into the deaths at Gosport eventually led to the public enquiry headed by Bishop James Jones, whose Report was published on 18 June 2018 (on which this paper is largely based).

What will happen next? The Portsmouth 'News' reported the following on 27 July 2018:

> "An investigation by a leading police officer into the historic deaths of hundreds of people at Gosport War Memorial Hospital will begin in September. Assistant Chief Constable Nick Downing, head of serious crime for Kent and Essex Police, will lead the review. Families have said there is enough evidence in the report itself for the Crown Prosecution Service to take the case on and start criminal proceedings. It comes after a four-year independent panel, led by Bishop James Jones, found 456 patients had their lives shortened while at the hospital between 1988 and 2000. The report, published last month, also found another 200 ‘probably’ had their lives shortened."

What can we expect? *The Sunday Times* carried a full-page article on 24 June 2018 which will help to answer that question. Under the title, **'The great NHS cover-up: opiate syringe may have killed thousands'**, it claimed that the Graseby syringe driver that had been used "for at least 30 years" by the NHS was faulty. It "led to the rapid infusion of dangerous doses of drugs into the bloodstream and made the behaviour of Dr Jane Barton – in charge of prescribing medicine on the Gosport wards – even more dangerous than had been thought." While conceding that the drugs has been "routinely and recklessly prescribed", the article sought to give the impression that the Gosport Report (which had just been published) was seriously defective and that its findings were unreliable. It closed with a short paragraph which many readers might not have noticed: "The Gosport panel said: 'These allegations are completely unfounded and without merit or support.'"

This is the kind of obfuscation and mud-slinging we can expect. Even if the Graseby syringe driver was prone to malfunction occasionally – which has not been proven – this factor alone could not even begin to account for the massive death toll at Gosport, the long period of time over which the killings took place, or the rather obvious fact that no other general hospital in the UK, all of which used the same device, had a death rate that was remotely close to the one at Gosport.

CONCLUSION

As Professor Darbyshire asked: "Where do we even begin? …The substance of this report into the killing fields of GWMH is as chilling as it is damning."

While it may seem churlish to find fault with the Report itself – since it provides a wealth of valuable factual information – it nonetheless fails to convey clearly and concisely the sheer horror of events at Gosport and the truly despicable attempts made by various authorities to cover them up. It constantly uses the bizarre euphemism, "shortened their lives", when referring to the cold-blooded murder of so many people. The moral revulsion of the Panel, such as it was, is never deemed worthy of more than an occasional expression of "surprise" in the text of the Report.

There are also two serious failures with the Report which ought to be a matter of concern. Firstly is its failure to acknowledge that the co-operation of so many people, both in the course of the killings and during the progress of the various investigations, must surely constitute one or more conspiracies. The evidence for this, as set out in the Report itself, is overwhelming. In all we identify six:

1. A conspiracy to operate over a ten year period a non-disclosed regime of involuntary euthanasia at the hospital, involving the hospital management, doctors and staff, including pharmacists and mortuary staff.

2. A conspiracy of silence to downplay to the greatest extent possible the existence of an extremely serious situation at the hospital, involving the hospital management and staff, the pharmacists, the coroners, regional health authorities, the police, elected representatives, the Crown Prosecution Service, the Department of Health, and members of the Government.

3. A conspiracy to withhold, conceal or suppress evidence of negligence and wrongdoing from patients' relatives and their representatives, involving the hospital management and staff, the regional health authorities, elected representatives, and the Department of Health.

4. A conspiracy in the national media over a period of fifteen years or more to withhold information from the public on developments at the hospital. This conspiracy has continued even after the publication of the Panel's report in June 2018, where the high profile coverage that one would normally expect of a tragedy of this magnitude is almost non-existent.

5. A conspiracy among the relevant police authorities to delay or obstruct effective scrutiny of developments at the hospital, to downplay the seriousness of the charges brought by the victim's relatives, to ignore the possibility that the unlawful killing at the hospital might be institutionalized and continuing, and to undermine the credibility and character of the relatives.

6. A conspiracy by the medical establishment, including the General Medical Council, to protect the reputations of staff and management at the hospital despite the overwhelming evidence of gross negligence and unlawful killing.

The Panel dismissed the very notion of collusion or a conspiracy when it said:

> **12.48** As this Report has shown, many disparate organisations were involved from 1998, and especially from 2000, spanning the health and justice systems. Between them, as is now clear from the documents, they failed to identify the nature of the underlying problem or to deal with it effectively. It is understandable that the families in particular have sought explanations as to why this was the case. There are two broad possibilities.
>
> **12.49** First, each organisation may have acted in its own interests and those of its leaders, motivated by reputation management, career self-preservation and taking the path of least resistance. This coincidence of interests would itself lead to identical responses across organisations, without there being a conspiracy between the organisations.
>
> **12.50** The second possibility is that there was collusion – a conspiracy between organisations to ensure that the views of the families were consistently frustrated. It is not clear what the underlying motivation would be for such a course, but it is understandable that the almost uniform consistency with which all concerns were dismissed and families were rebuffed might lead to suspicions of collusion or conspiracy between organisations.

> **12.51** The documents the Panel has reviewed do not contain evidence in support of such collusion or conspiracy. They show that the underlying explanation is the tendency of individuals in organisations, when faced with serious allegations, to handle them in a way that limits the impact on the organisation and its perceived reputation. This does not diminish the importance or the impact of organisations acting similarly and prioritising compliance with their own processes. Too readily opting for what is convenient within an organisational setting is the enemy of recognising the real significance of concerns and allegations.

These conclusions by the Panel members display a shameful disregard for the evidence before them. There is no reason whatever why the "coincidence of interests would itself lead to identical responses" (12.49) – unless there was collusion at some level. The Panel pleads its case on the basis that the documents it reviewed did not contain evidence of collusion (12.51), but this too is ridiculous. The documents could not be expected to do so! Conspirators do not normally leave evidence of their collusion on file, and where they have done so inadvertently they take steps to recover and destroy the files (which is known to have happened at Gosport). Furthermore, the Panel's argument that the investigatory organisations would have damaged their reputations if they found evidence of malpractice at Gosport is equally absurd. In what sense has the reputation of Hampshire Constabulary been enhanced through its repeated failure to deal adequately and in a professional manner with events at Gosport?

These sections of the Report – 12.48 - 12.51 – play right into the hands of those who have no desire to see the full extent of the wrongdoing in this matter brought plainly to public attention.

In addition to this we have the remarkable admission on p.191 of the Report that the wards in which the killings were carried out had NO facilities to provide patients with intravenous hydration. It wasn't even necessary under such circumstances to use a fatal dose of opiates; a high level of sedation alone would have been sufficient to kill an elderly victim in 3-4 days. (As we noted earlier, Mr Ripley, who was urgently removed to another hospital for treatment, was found to be dangerously dehydrated and would surely have died without this intervention.) It beggars belief that the Panel should gloss over a fact of such importance, a fact which shows beyond all doubt that the patients at Gosport were being systematically selected for euthanasia.

> **"Their feet run to evil, and they make haste to shed innocent blood: their thoughts are thoughts of iniquity; wasting and destruction are in their paths." – Isaiah 59:7**

Euthanasia and the New World Order

Let's summarize what actually happened at Gosport, based on the facts set out in the Report:

1. A group of medical staff working at or in close affiliation with Gosport Hospital conspired together over a ten-year period to murder between 650 and 850 elderly patients.
2. Staff and relatives who raised the alarm were repeatedly vilified.
3. Consistent efforts were made by staff in the health and justice systems over a period of 20 years or so to obstruct any attempt to expose wrongdoing at Gosport.
4. Where professional or judicial assessments were made, the verdicts showed an absurd disregard for the evidence of culpability and the heinous extent of the crime.
5. Had the relatives not persisted valiantly in their campaign for justice – over a 20 year period! – the mass killing at Gosport would have been forgotten.

The average person has great difficulty digesting these highly unpalatable facts. It makes absolutely no sense to kill large numbers of people in this way – unless such a death mill was part of a larger plan. And it is. The architects of the New World Order have long boasted that population control would be imposed on a worldwide basis. This would include the elimination of what they like to call "useless eaters", people whose net economic input to society is negative. Since voluntary euthanasia will make only a minor contribution to the reduction they are seeking, they must weaken popular resistance to the idea of euthanasia as a means of population control.

This will entail placing a qualitative value on human life. In an article on the Gosport Report in the *Weekly Standard* on 29 June 2018, Christine Rosen, the managing editor, suggested that the use of euphemisms like "shortening the lives" instead of *murder* or *unlawful killing* is designed to "encourage an understanding of human life as a qualitative resource whose value could be abstracted, measured, and acted upon accordingly."

This, in our opinion, is an accurate assessment of what has been happening. A variant of this idea is already being tried in China. *The Independent* reported on 22 October 2016 that a high-level policy document had just been released by the Chinese government in which it announced its intention to collect all available data on over 800 million citizens and assign them a value based on their compliance with socially constructive policies. As *The Independent* stated:

> "The government hasn't announced exactly how the plan will work – for example, how scores will be compiled and different qualities weighted against one another. But the idea is that good behaviour will be rewarded and bad behaviour punished, with the Communist Party acting as the ultimate judge."

A Totalitarian Experiment

The Gosport death mill would seem to have been a totalitarian experiment along similar lines, where individuals with a low score on the "social credit system" were eliminated. The exercise was conducted in a blatant, even crude way, as if to test the length to which the public would go to resist involuntary euthanasia – 'We killed more than 600 people – what are you going to do about it?' The subsequent ineffectual efforts by relatives to get past the countless barriers placed in their path was proof that the individual is largely powerless when opposed in this way by the state. The many investigations and reports, all of which came to nothing, were merely a way of conditioning the public to accept the inevitability of euthanasia.

Those who have studied the methods used by the architects of the New World Order call this 'programmed helplessness'. It's a way of getting the masses to believe that 'resistance is futile'.

Before closing, we would note yet another glaring hole in the Gosport Report, namely its failure to advert to the existence of a network across the UK which connects all of the organisations mentioned in the Report. That network, of course, is Freemasonry – a powerful, undemocratic, anti-Christian cult. It is the principal operational arm for the New World Order in the UK and elsewhere. The British police authorities are infested with it, as is the judicial system. The military, too, have long been a bastion of Freemasonry – we would note, in passing, that Gosport War Memorial Hospital has close ties with the Royal Navy base at Portsmouth.

Unless one understands the bigger picture – the New World Order, the intense pressure to legalize euthanasia, and the highly subversive role played by Freemasonry in British society – the otherwise inexplicable events at Gosport, and the suppression of all attempts to expose them, will continue to puzzle the average person.

Remember, Satan's methods are also those of his earthly servants, **"to smite with the fist of wickedness" (Isaiah 58:4)** and not get caught.

_____

Jeremy James
Ireland
July 29, 2018

- SPECIAL REQUEST -

Regular readers are encouraged to download the papers on this website for safekeeping and future reference. They may not always be available. We are rapidly moving into an era where material of this kind may be obtained only via email. Readers who wish to be included on a future mailing list are welcome to contact me at **jeremypauljames@gmail.com**. A name is not required, just an email address.

For further information visit www.zephaniah.eu